Introduction

Male involvement in family planning (FP) means more than increasing the number of men using condoms and having vasectomies; male involvement also includes the number of men who encourage and support their partner and their peers to use FP and who influence the policy environment to be more conducive to developing male-related programs. In this context "male involvement" should be understood in a much broader sense than male contraception, and should refer to all organizational activities aimed at men as a discrete group which have the objective of increasing the acceptability and prevalence of family-planning practice of either sex.

In the past, family-planning programs have focused attention primarily on women, because of the need to free women from excessive child-bearing, and to reduce maternal and infant mortality through the use of modern methods of contraception. Most of the family-planning services were offered within maternal and child health (MCH) centers, most research and information campaigns focused on women. This focus on women has reinforced the belief that family planning is largely a woman's business, with the man playing a very peripheral role.

Involving men and obtaining their support and commitment to family planning is of crucial importance in the Africa region, given their elevated position in the African society. Most decisions that affect family life are made by men. Most decisions that affect political life are made by men. Men hold positions of leadership and influence from the family unit right through the national level (IPPF, 1984). The involvement of men in family planning would therefore not only ease the responsibility borne by women in terms of decision-making for family-planning matters, but would also accelerate the understanding and practice of family planning in general (ibid.).

Only recently have family-planning associations recognized the importance of men's role and motivation in fertility decision making, particularly in Africa. But now that this has been recognized, the question is "what can family-planning and reproductive-health programs do to encourage men's cooperation?" (Hawkins, 1992; *Population Reports*, 1994).

Some programs have developed IEC campaigns aimed at increasing the awareness and knowledge of men. However, one of the crucial questions now facing these programs is how to move beyond increasing knowledge to changing attitudes and practice. How to address the needs of men through different service-delivery strategies is also an important question (Hawkins, 1992).

Various service-delivery strategies to meet those needs can be provided in a variety of ways, including primary health care facilities, special hours for men in MCH/FP

clinics, male-only clinics, STDs clinics, integration of FP promotion in AIDS prevention programs, mobile units, organized groups, income generating schemes, employment-based programs, youth programs and peer counseling, male-to-male community-based distribution of condoms, social marketing, involvement of private agencies and medical practitioners.

This paper highlights some of the key factors influencing contraceptive use, gives a brief summary of the literature on selected male-involvement initiatives taken in Africa, attempts to draw lessons learned from those initiatives, and then suggests some recommendations for the next steps.

Factors Affecting Contraceptive Use

Many factors, of course, affect women's and men's contraceptive use, but there are three key elements which deserve to be highlighted.

1. Men's support or opposition to their partners' practice of family planning has a strong impact on contraceptive use in many parts of the world, including Africa. Within marriage in Africa, men typically have more say than women in the decision to use contraception and in the number of children that the couple will have.

For example, according to the 1984 Zimbabwe Reproductive Health Survey, 42 percent of married women stated that it was the husband's responsibility to decide whether his wife should use FP methods. Focus groups conducted by Zimbabwe National Family Planning Council (ZNFPC) and a private research agency suggested "that men were the ultimate decision makers on family size and FP matters in Zimbabwe." (Piotrow et al., 1992).

In Ghana, "despite the independent nature of some marital relationships, recent evidence indicates that men have the primary decision-making power in matters of FP." Both DHS data and focus-group research reveal that the husband is usually the effective decision-maker about fertility. Furthermore, husbands' family-planning attitudes and fertility goals usually are not influenced by those of their wives. And, when partners disagree on whether to use family planning, the man's preference usually dominates (*Population Reports*, 1994). Also, "There is a reason to suspect that men comprehend FP messages differently than women do. Men felt that financial considerations were the primary motivation for FP use, whereas women reported that health and the need for women to 'rest' were the primary motivations for use" (ibid).

According to an analysis from DHS surveys, the mean ideal family size for currently married men is higher than for married women. This difference is significant in West Africa, ranging from about two children in Burkina Faso to more than four

children in Niger and Senegal (exception is Ghana, 0.6). In East and North Africa, no significant difference in fertility desire was found. This shows the importance of targeting men with FP programs (Ezeh et al., 1996).

The husband's support is found to be a good predictor of future practice and continued use. There are studies done in the Philippines which indicate that the continuation rate among women whose husbands support their contraceptive practice is much higher than those whose husbands do not give support to their wives (IPPF, 1984). In South Korea researchers found that 71 percent of women whose husbands approved family planning had used contraception at some time, compared with 23 percent of women whose husbands did not approve (*Population Reports*, 1994). In Madagascar, Norplant continuation rates were higher after one year among couples in which the husband had been involved in the decision-making process, and among these couples both wives and husbands were more satisfied with Norplant than those in which only the wife was counseled (Tapsoba et al., 1993).

2. Spouse communication is positively associated with contraceptive use: DHS data from seven African countries (Botswana, Burundi, Ghana, Kenya, Senegal, Sudan, and Togo) show that the percentage of women using modern contraceptives is consistently higher in the group that had discussed FP with their husbands in the year before the interview than in the group that had not (JHU/PIP, 1994).

Because of lack of communication, many women do not know what their husbands think about FP. Many women think that their husbands disapprove of FP, when in fact the husband approves. In West Africa, about three quarters of the men and women had not discussed family planning with their spouse in the year preceding the survey, except in Ghana and Cameroon where the proportions were about one-half and two-thirds respectively. In East Africa, the figure is less than 40 percent, except in Burundi and Tanzania (Ezeh et al., 1996). In Burundi, 94 percent of men surveyed approved of contraceptive use, but only 48 percent had discussed it with their wives in the preceding year. (*Population Reports*, 1994). According to a 1993 DHS survey, 45 percent of married women in Tanzania either did not know what their husbands thought about FP or thought their husbands disapproved of family planning, when in fact many of the husbands approved.

3. Men's lack of access to services has been a barrier to family-planning use. Men cannot share responsibility for reproductive health and family planning if services and information do not reach them. Most FP clinics cater to women, so men are uncomfortable about going to these clinics. Men must be reached in other ways. This testimony from a Kenyan man is a good illustration of that need: "After having three children, my wife went on the pill for her contraception because we could no longer afford an accident with

the natural methods we were using. Her blood pressure immediately shot up, and she was advised to discontinue. She tried other methods, but they had complications too. I felt I was unfair and it was my duty, too, to take part in family planning. One morning we went together to our local family-planning clinic. I will never forget how embarrassed I felt. There was not even a single man there, just queues of women and their babies. This was a woman's world and I felt totally lost." (Wambui, 1995). This confirms the assumption that no matter how many men want to know about and utilize contraception, most family-planning programs have not yet given adequate attention to serving them.

Male Involvement Initiatives in Africa

There are some examples of experience and initiatives in various forms which illustrate a genuine concern and creative approach toward achieving greater male involvement in family planning in Africa. Programs to encourage men's involvement in family planning are expanding, especially through interventions to increase knowledge and interest of men, such as information, education, and communication campaigns using mass media, and interventions to increase access and use of FP services by men such as community-based distribution, condom sales and promotion, workplace programs, and a few male clinics and vasectomy services. Some of the field experiences have shown that well-targeted, focused male-involvement programs can have an impact on both male and female behaviors related to reproductive health.

Interventions to Increase Knowledge and Interest of Men

Promotional Campaigns

Zimbabwe

In 1988–89, the Zimbabwe National Family Planning Council (ZNFPC) conducted a national education project targeting men, the first of its kind for sub-Saharan Africa. Funded by USAID with technical assistance from the Johns Hopkins University Population Communication Services (JHU/PCS) program, the project was designed to increase men's knowledge of, and promote more favorable attitudes toward, family planning, increase modern family-planning methods, and promote joint decision making.

The project used a radio serial drama, educational talks for men, and family-planning leaflets to promote these messages. An extensive evaluation found the radio drama to be the most effective method for reaching about two of every five men in both urban and rural areas. Of the other methods, the talks reached 11 percent of men, and the leaflets reached 5 percent. The proportion of men who reported

joint decision making in family planning rose from 25 percent to 35 percent from 1988 to 1989 (Chirambo, 1992).

Analysis of survey results from the first study (which controlled for demographic variables and radio ownership) found that men who were exposed to the campaign were 1.4 times as likely to use a modern family-planning method as were other men, 1.7 times as likely to use condoms, and 1.4 times as likely to believe that both husband and wife should participate in deciding how many children to have. However, the campaign was not entirely successful in promoting the idea of joint decision-making, because men who were exposed to the campaign were 2.4 times more likely than others to state that the husband alone decides whether to practice family planning (Kim, et al., 1996). But positive lessons from this first campaign were that Zimbabwean men want to learn more about family planning, and that communication materials directed at men can change men's attitudes towards family planning, stimulate discussion between husbands and wives, and motivate men to support the practice of family planning.

A second male-motivation campaign was launched in 1993, drawing heavily on the lessons learned during the first campaign, again to encourage male involvement in family planning and to encourage use of long-term methods to limit family size. This second campaign used a wide variety of media to reach more men and to expose them to multiple, reinforcing sources of information: radio, television, posters, newspapers, motivational talks, family festivals, a football tournament with giant puppet shows at half-time, live dramas, and musical shows. This campaign also focused on improving the quality of services by developing a new training curriculum and a video on counseling and interpersonal communication, and trained clinic-based health workers and community-based distribution agents.

A post-campaign evaluation showed that 88 percent of adults living in the campaign areas were exposed to at least one campaign material or activity. Again radio had the greatest reach, 62 percent of men, followed by print materials (posters, newspapers and magazines, and pamphlets reached 57 percent, 48 percent, and 46 percent of men, respectively). Football matches drew far larger audiences (18 percent of men) than any other type of community event. Exposure to the campaign was associated with a rise in use of modern contraceptives. Before the campaign, contraceptive demand was declining as a result of increases in contraceptive prices and primary health care fees. With the launch of the campaign, this trend reversed, and contraceptive demand, especially for long-term methods, began to rise. People exposed to three or more campaign components were 1.6 times as likely as others to use a modern contraceptive method.

According to the surveys, knowledge of long-term and permanent methods rose over the campaign period as did the number of people holding positive attitudes

toward them. The campaign also encouraged couples to communicate more about family planning and to decide jointly on a contraceptive method. The proportion who reported discussing family planning with their spouses or partners rose from 37 percent to 57 percent. Twenty-nine percent of men who were exposed to four or more campaign components reported that they had discussed family planning with their partners, consulted service providers, or adopted modern contraceptive methods, compared with 16 percent of men exposed to two or three components, and 2 percent of men exposed to just one component or none. As men became more interested in family planning, many wanted to play an active role in the decision-making process. Rather than leaving family planning decisions to their wives or partners, men were more likely after the campaign to believe that they alone should be responsible for making such decisions or that decisions should be made jointly. The rise in interest in solely male decision-making recorded by the surveys suggests that the campaign's reliance on traditional masculine images may have reinforced stereotypes about male decision-making and blurred campaign messages about the value of joint decision-making (Kim, et al., 1996).

Ghana

In September 1987, the Health Education Division of Ghana's Ministry of Health (MOH/HED) began a systematic family-planning IEC project with funding from USAID and technical assistance from JHU/PCS. The goals of the first phase of the project were to 1) increase knowledge of, and improve attitudes toward, family planning and promote contraceptive use among men and women of reproductive age, 2) enhance family-planning counseling skills among MOH service providers, and 3) strengthen the MOH's ability to develop, implement, monitor, and evaluate communication programs in health. The project used situational analysis, service provider training, and IEC material development and mobilization for two campaigns in three regions before expanding the campaign to remaining areas. The project used a wide variety of IEC material, media, and activities, including leaflets and booklets, motivational posters, national radio and television broadcasts, drama, a theme song, community audiovisual material, and community activities.

The second phase of the project highlighted male involvement in family planning. A November 1991 study of the project found that almost all males surveyed in six regions had seen or heard at least oneIEC family planning campaign medium. In the Ashanti, Brong-Ahafo, and Central Regions where more intensive campaigns were run, more men were reached than in other regions. Findings indicate a significant increase in men's family planning knowledge and practice, and improvement in attitude with the increasing length of the project. Also, among those men exposed to the intensive campaign, 47 percent had discussed family planning with their partners, and 26 percent stated that they or their partners were using a more modern contraceptive method (Kim et al., 1992).

Niger

In 1987, Niger's Ministry of Health and Social Affairs (MOHSA) of the Directorate of Family Planning initiated a communication project in collaboration with the JHU/PCS. The project included an IEC campaign with three objectives: 1) to increase public awareness of modern methods of child spacing, 2) to reinforce positive attitudes toward contraceptive use, and 3) to motivate potential clients to seek family-planning services. Project activities took place over a two year period in Niger's capital, Niamey, and in the two urban centers of Maradi and Zinder. Project activities included a communication workshop for program managers, a national family-planning logo design, focus group discussions, two awareness seminars for opinion and political leaders, a series of radio and television broadcast dramas with family-planning themes, and contraceptive sample kits for health agents.

The project was not targeted to men exclusively. However, a post-project survey found that the project had contributed to positive changes in men's knowledge and attitudes: a 21 percent improvement in their ability to name one or more contraceptive methods without assistance; an 11 percent increase in approval of the use of contraceptives for birth spacing; men's exposure to television programs with family-planning themes increased by 94 percent; men's reports of hearing a radio program with a family-planning theme increased by 47 percent.

Recommendations for the project included, among others, targeting men as a primary audience for family-planning messages; developing messages targeted to men that emphasize the economic benefit of having fewer children; creating a new role model for men that portrays responsible men as those who discuss family planning with their partners; expanding awareness-raising into organized male networks, such as the political parties, employers, unions, the military, and paramilitary; using male Social Affairs agents to reassure men that society views family planning as desirable and responsible (Bashin et al., 1989).

Nigeria

The Planned Parenthood Federation of Nigeria (PPFN) conducted programs to enhance male motivation. These included educational outreach to leaders, family life education for youth, and reaching men through existing groups. Government officials, traditional rulers, and religious leaders were among those targeted, as were journalists, health educators, teachers, social workers, and agricultural extension workers. PPFN also made contacts with Nigerian Army units and the police. PPFN saw significant progress in developing program guidelines and initiating collaboration withother organizations (IPPF, 1984).

Campaign for Vasectomy Promotion

The Kenya Vasectomy Promotion Project, sponsored by JHU/PCS and the Association for Voluntary and Safe Contraception (AVSC), was designed to increase potential acceptors' knowledge of vasectomy. Messages stress that the vasectomy procedure is simple and safe, that men who have vasectomies remain healthy and virile, and that "wives love it because they no longer fear an accidental pregnancy." Wives in the television commercials: "He's strong really . . . We have great sex!" Radio, television, and newspaper ads also direct men to visit Kencom House, the male-only clinic in Nairobi, where specially trained male service providers and counselors make men feel welcome. Potential clients can also write or access a special telephone hotline for more information (Kumah, et al., n.d.).

Campaign for Employer-based Programs

In 1987, the Planned Parenthood Association of Zambia (PPAZ) launched a male-involvement campaign that included a campaign for industrial workers, targeting the working man. Since that time, PPAZ has held discussions with employers to encourage them to include family-planning services in work-site clinics. PPAZ has also been invited to give talks by the labor and social security ministry and at labor union meetings.

In 1984, John Snow, Inc., in conjunction with the National Council for Population and Development and funded by USAID, began the Family Planning Private Sector Programme in Kenya to help private companies and NGOs expand health services to their employees by including family planning. Health workers conducted education sessions in the workplace, as well as providing health services. The program also encouraged employers to form their own community-based committees that included representatives from management, unions, and workers to plan information and education programs. Cashew, tea, and sugar companies and paper mills were among the 30 employers involved in the program, all of which employ mainly men. The program aimed to recruit at least 30,000 new family-planning clients. No results were given for this program (*Population Reports*, 1986).

In 1989, with the support of AVSC, Mulanje Mission Hospital in rural Malawi took a leading role in increasing male participation in family planning by initiating a "child spacing club" for men. This club—modeled on the Man to Man program in Blantyre, an initiative of the NGO Banja La Mtsogolo—initiated educational seminars for male hospital staff ranging from grounds keepers to nurses; the club also took their child-spacing messages to two rural villages and a tea estate. One of the villages and the tea estate had asked to be involved after hearing about the project. Workshops were held at village meeting places, and over a seven-month period, 320 men actively participated in workshops, with many men requesting further learning

opportunities. Many of the men cited their exclusion from previous education and counseling opportunities as the reason for their lack of involvement in the past. As a result of the Mulanje Mission Hospital effort, the Mulanje staff have had more requests for visits than they can handle from other villages. The project has operated at very low cost to AVSC—only for educational materials and gasoline—while the staff have contributed their time and enthusiasm. As of November 1992, a second mission hospital was due to start a similar club (Mason, 1992).

Fathers' Clubs

In 1981, the Ministry of Health and Social Affairs in Mauritania launched a school for fathers to sensitize men to women's health problems and family planning. Fathers meet monthly to discuss issues that impact children and women. In 1984, the project expanded to include a weekly school for husbands, aimed at informing young men who do not yet have children about family health. No information is given about the results or effectiveness of the program (*Population Reports*, 1986).

A fathers' club initiated by the family health clinic of the Institute of Child Health and Primary Care of the University of Lagos, Nigeria, is credited with increasing awareness of family planning between 1975 and 1982. The fathers' club was one of the clinic's strategies for gaining support for family-planning and child health programs (Olukoya, 1985).

The Planned Parenthood Association of Ghana (PPAG) sponsored three pilot "Daddies Clubs" through its special Male Motivation and Planned Parenthood project in 1980. These clubs were employer-based, located at the Pretsea Oil-Palm Plantation (Western Region), among Dungu Amasachina Young Farmers (Northern Region) and at the Tafo Cocoa Research Institute of Ghana (CRIG). Of these, the Pretsea project was the most successful. In 1982 alone, about 5,000 people were contacted, about 4,000 of them through lectures and discussion groups. About 1,620 were contacted through 450 follow-up visits to their homes. A total of 1,519 acceptors were recruited, of whom 1,310 were for non-clinical contraceptives and 209 for clinical services. The clinical acceptors were mostly women encouraged by their husbands to seek services. In addition to contraceptive services, the Pretsea program offered services regarding subfertility and infertility. Of the eight cases receiving treatment at the PPAG clinic, two women became pregnant. News about this side of family planning helped spread the word about the program, gained it further credibility, and attracted more people to the Daddies Club. These successes are credited with raising membership in the club from 25 to 100 (IPPF,1984).

Sporting Events

"Ghanaian family-planning professionals have hit upon an innovative new scheme to get men and women talking about family planning. They sponsor tournaments of games that men like to play, such as soccer, tug-of-war, and checkers. Then they recruit the wives to oppose the men, altering the rules where necessary to make a fair match. Male soccer players are only allowed to use their left foot, for instance, and the female tug-of-war team is allowed extra members. The couples enjoy the matches, and the winners are given a gallon of condoms, or another prize that will spark conversation about family planning. Results seem to be good. Couples are talking, and family planning is losing its wicked connotations. Half of the reduction in fertility in one rural area in Ghana appears due to the acceptance of family planning by men." (Ellerston, 1992).

In Zimbabwe, a "Family Planning Challenge Cup" soccer match is used to mobilize men and attract them to the family-planning message. Each of the three tournament games played by four of Zimbabwe's top soccer teams attracted over 30,000 spectators, mostly men. Soccer was used as the image for the campaign along with the slogans "Play the Game Right" and "The Dream Team" (the latter being the nickname Zimbabweans give their national soccer team), which were used for billboards, t-shirts, and newspaper and television ads (Kumah, et al., n.d.).

Interventions to Increase Access and Use of FP Services by Men

Male Clinic

In March 1993, the first Family Planning Centre for Men (as part of the Population and Health Services/Marie Stopes Clinics) opened in Nairobi, Kenya, to provide vasectomy services, counseling, and other male reproductive health services in a confidential environment. In June 1993, the second Centre for Men was opened in Mombasa. This center offers two evening sessions of two hours per week. The need for these centers was identified during formative research conducted by Innovative Communication Systems as part of a campaign to increase vasectomy awareness and acceptance in Kenya. Since these first two centers opened, four more have been added. AVSC has provided training for Kenyan surgeons in no-scalpel vasectomy in connection with these centers. In addition, AVSC conducted IEC activities, largely through mass-media advertising, particularly via radio, to get basic information about vasectomy out to men. They also ran newspaper ads with coupons that could be returned to get more information. AVSC found that the number of men who used the Centre for Men rose sharply following each ad campaign. Through the experiences with the centers for men, AVSC has learned that men are interested in family planning. The majority of men don't want children they cannot care for. Men need good counseling and reproductive health services (Danforth, 1994).

Community-based Programs

Kenya

A March 1995 report by the Population Council's Africa Operations Research and Technical Assistance project, funded by USAID, describes a study undertaken in Kenya to gain programmatic experience in using community-based distribution agents trained to focus specifically on reaching males. In addition, insights were gained on the relative effectiveness of using trained teams of only men, trained teams of only women, and trained teams of both men and women in promoting and providing family-planning services and in educating men and women about HIV/AIDS. Previously, the assumption had prevailed that female CBD agents can discuss family planning or distribute contraceptives to women more effectively than male CBD agents. Evidence from this study held that this may not necessarily be true and that there is much to gain by using male CBD agents,particularly given that men who do not have regular jobs can devote more time to CBD activities, whereas women agents have household and other chores in addition to their CBD activities.

The following were among the findings of the study: all agents interviewed recommended a mixed group of male and female agents; involving males, both as distributors and as targets for family-planning activities and services resulted in a greater use of family planning by men and increased communication between spouses; education for HIV/AIDS prevention resulted in a sharp increase in positive behavior change among males, with little change for women; and HIV/AIDS education did not lead to greater discussion of the subject among partners (Population Council & FPAK, 1995).

Beginning in 1983, the Nairobi-based African Medical and Research Foundation (AMREF), with funding from USAID, ran training programs for shopkeepers in distributing non-prescription contraceptives to their customers. The scheme took advantage of community trust in the shopkeepers and the shopkeepers' experience in distributing drugs. To help shopkeepers learn to supply contraceptives and dispense commercial drugs more effectively, training focused on such topics as communications and client management, primary health, modern and traditional contraceptive methods, background instruction about Kenya's population growth, the importance of seeing the husband and wife together, and when to refer customers to a health center. In this scheme, most of the shopkeepers were men. The shopkeepers worked on a volunteer basis and gave free contraceptives without commission, citing their willingness to do something for their communities as their motivation (Mbuya, 1986).

Ghana

As part of the Ghana National Family Planning Program, GNFPP, mobile family-planning teams were organized to provide birth-control services to villages in the Danfa region. The staff of MCH centers and village-based primary health care workers supplemented the work of the GNFPP. Early in this effort, it was clear that family-planning services for men would be an important element, since nearly half the clients of these services were men. The program had several notable results: men proved to be better family-planning advocates than women; more men tried to persuade their friends to use contraceptives than did women; men who chose birth control for either themselves or their partners reported that their partners had fewer pregnancies than did women who participated directly in the program. An evaluation of the GNFPP by the School of Public Health at the University of California at Los Angeles attributes at least one-half of the fertility reduction in Danfa to male acceptance of contraception. Lessons learned showed that men in Danfa preferred visiting the mobile clinics for obtaining condoms, rather than buying them in a store, which required their traveling outside the village. However, this must be balanced against tying programs to formal health services that in other cases may be less mobile and more costly in terms of personnel. Community-based programs were seen as having the greatest opportunity for increasing men's use of birth control (IPPF, 1984).

Between 1980 and 1982, the Planned Parenthood Association of Ghana (PPAG) conducted community-based distribution through 203 outlets, 133 of which were in urban and 70 in rural communities. One hundred twenty were administered by PPAG and 83 were administered by CBD agents who received token incentives for their involvement. Agents were often recruited from other PPAG programs. For example, agents at the Tafo Cocoa Research Institute of Ghana (CRIG) and the Pretsea Oil Palm Plantation were the secretaries of Daddies Clubs at those companies. Agents worked through pharmacies, maternity homes, groceries, banks, police and military barracks, and other points throughout the community in collaboration with PPAG to deliver non-clinical contraceptives. PPAG also has worked with local traditional birth attendants, some of whom are men, and given them training as CBD agents. TBAs were found to be very effective because of their credibility in their communities and their frequent contact with community members, whom they serve as traditional doctors. PPAG recruited about 100,000 acceptors through its CBD projects. Seven hundred boxes of condoms, 174,700 tubes of Neo-Sampoon, and 23,300 cycles of pills were distributed (IPPF, 1984).

Planned Parenthood of Ghana offered a "cafeteria style" series of lectures on topics of interest and concern to men. The most popular lectures selected were on AIDS, impotence, the breakdown of relationships, and male and female physiology. Delivering the lectures to existing groups of men such as workers' committees, clubs, or

other groups has led to PPAG's success with the program. PPAG workers stress that family planning is to help couples have the number of children they want, which is up to each couple. They also emphasize the infertility services that family-planning associations offer. CBD programs back up the PPAG effort by making contraceptives available, for which family-planning field workers earn a 10 percent commission on the supplies they sell (Ellerston, 1992).

Swaziland

"Man Talk" was a program in Swaziland in which men who have been trained in communication talk with other men one-to-one in bars, pool halls, clubs, and factories. Other activities include distributing educational leaflets, motivational materials, and condoms and working with local business owners. An example of a result from this effort is that the owner of a nightclub was persuaded to install a condom dispensing machine in the men's restroom. At the time this activity was documented, negotiations were underway for a condom machine in the women's restroom (ibid).

Social Marketing

In Ghana in 1986, the SOMARC project of the Futures Group, funded by USAID, undertook a condom-marketing project aimed at middle- and lower-middle-class married men between 26 and 35 years old who had a secondary-school education. Panther condoms, the brand marketed, already had some name recognition from previous availability, though the condoms had not been sold since 1978. The theme for the campaign was "Panther Condoms Are Back." Television, radio, print, and point of purchase advertising were rolled out in four phases, with progressively more specific messages regarding family planning, generic condom advertising, trade advertising, and brand-specific advertising. Research was conducted to evaluate the effectiveness of these interventions in improving male attitudes toward the condom and in stimulating acceptance and use. More than 80 percent of the men in a 1991 urban sample knew the brand name, up from 50 percent in 1988. Men who had ever used a Panther condom increased from 12 percent in 1988 to nearly 50 percent in 1991, and nearly 60 percent of men who recalled a condom ad remembered Panther. Over 25 percent of all men in the sample claimed they were using a condom regularly, up from 9 percent of men in 1988. A 1990 consumer profile showed that over 42 percent of Panther users had never used contraception before they started using Panther. Thirty-six percent had switched from a less effective method, and 16 percent had switched from another brand or a more effective contraceptive. Ninety-eight percent of users were middle or lower-middle class, 89 percent had some secondary education, 57 percent were married, and 31 percent were younger than 25 years old. The majority of users were satisfied with the product

overall and intended to continue using it. Availability, quality, low price, and the advertising were the main reasons users chose Panther (Tipping, 1991).

Roles of Male Opinion Leaders

From 1991 to 1993, an operations-research study was conducted by the Population Council and the Ministry of Public Health of Cameroon on the role of male opinion leaders in promoting and delivering family-planning services in rural areas. In this study, which was supported by USAID, KAP surveys were conducted before and after the intervention period of 12 months. During the 12-month period, male opinion leaders (MOLs) were trained in a variety of health interventions, including family planning, treatment of diarrhea, and antenatal and vaccination referrals, and completed IEC activities in rural areas surrounding Nkambe in Cameroon's northwest province. The MOLs received one-week initial training and three refresher courses during the intervention period. MOLs were supervised at the district level and worked in tandem with traditional birth attendants.

The results of the study indicate that MOLs were very active in delivering health interventions in rural areas, as shown by an average of 90 percent submission of monthly activity reports by MOLs. The effectiveness of their performance improved with successive refresher courses.

In the populations served, the pre-intervention KAP survey indicated that knowledge of specific family-planning methods was relatively low for both men and women. After the MOLs' intervention, levels of knowledge for all methods rose, with a dramatic change in knowledge of condoms and spermicides specifically. In the male sample, knowledge of condoms increased from 52 percent to 81 percent; for women, knowledge increased from 47 percent to 72 percent. For spermicides, men's knowledge increased from 12 percent to 44 percent, and women's knowledge increased from 17 percent to 42 percent. More than 6,000 condoms and nearly 4,500 spermicides were distributed in villages during the intervention period.

Approval of family planning only rose slightly, attributable to already positive attitudes noted in the pre-intervention survey. However, there remained a meaningful percentage of men (14.1 percent) and women (13.5 percent) who disapproved of family planning after the intervention period. In the post-intervention KAP survey, 34.6 percent of men and 40.1 percent of women had benefitted from MOL service provision. The target population was generally satisfied with the IEC activities theMOLs conducted (Population Council, 1993).

Family Life Education Programs for Youth

Between 1980 and 1982, the Planned Parenthood Association of Ghana (PPAG) reached out to about 200 schools and youth organizations, and contacted nearly 90,000 people through Family Life Education (FLE) programs, referring about 15,000 acceptors for clinical and non-clinical services. This was achieved through specially organized lectures, film shows and educational materials. The programs were individualized to the needs of each institution and the group targeted, based on their age and experience. The program has raised some important issues on curriculum development and the whole question of how FLE should be effectively organized and introduced into the school system. As a result, the Ministry of Education began pilot FLE programs in selected schools, for a later introduction of FLE in due course into all second-cycle institutions in Ghana.

Counseling was found to be an important component of FLE, and PPAG was joined by another organization, the Christian Council of Ghana, for the training of 103 counselors. The YMCA of Ghana also joined the initiative, and trained more FLE counselors to be used at the grass-roots level to produce a multiplier effect. In 1981–1982 about 19,000 people were contacted with nearly 9,000 referrals made to the nearest Family Planning Clinics for service (IPPF, 1984).

Lessons Learned

- A well-designed and well-focused IEC campaign can have a positive impact on men by increasing their knowledge and improving their attitudes toward FP; this impact, in turn, will increase joint decision-making and promote contraceptive use for men and women. Well-designed family-planning campaigns can reach men by using multiple communication channels that appeal to them (such as radio dramas and sporting events) and by developing messages that relate FP support/use to responsible fatherhood and virile images. But one needs to be particularly careful not to reinforce the stereotype of male decision makers, and thereby reduce women's roles in making decisions, since women will still be the main users of contraception, given the diversity of female methods.

- Campaigns focused on work-site clinics are usually well perceived, as employers quickly pick up the benefits of FP programs for the company: fewer sick and maternity leaves, fewer child allowances. Also these campaigns can be cost-effective, given the high concentration of the target population in a relatively small area, as proven by the Malawi Mulanje Hospital's example.

Lessons Learned

- Innovative programs, such as the use of support groups, sporting events, fathers' clubs, and male opinion leaders, are excellent and give the opportunity to involve more men in program design and implementation. They demystify FP, and remove its negative connotations. The successes from Malawi's "Man to Man" and Swaziland's "Man Talk" initiatives show that using men to inform and educate other men about family-planning works. Male opinion leaders are underutilized and often ignored in family-planning programs. Given the strong credibility and respect they have within their communities, they can be very effective in promoting and delivering family-planning services in rural areas (especially condoms and spermicides) for both men and women.

- CBD programs have a great potential for increasing men's use of contraceptives. Men trained as CBD agents can be very effective in reaching both men and women, and can be more sustained advocates than women, because they can devote more time to CBD activities, as proven by the OR study in Kenya. But, it is very important to chose CBD agents from people who already enjoy community trust and respect. There is no standard rule for involving CBD agents that we can learn from the programs. Kenya shopkeepers and Cameroon male opinion leaders chose to be volunteers, while agents from the Ghana CBD program earned a 10 percent commission on the supplies they sell. The most important element is motivation.

- Social marketing is a strong channel to sell a contraceptive method, specifically condoms, if good advertising is coupled with availability, quality, and low price of the product. But one needs to be careful about the messages. In the SOMARC program, 16 percent of men acceptors had switched from another brand or a more effective contraceptive, which was not the intended impact. This supports the conclusion from some program managers that, while AIDS appears to have caused an increase in the use of condoms, it has not necessarily increased the usage of the condom as a family-planning measure (Chirambo, 1992).

- Vasectomy can be accepted in Africa if good counseling and quality services are associated with a strong information and sensitization campaign, as proven by the success of the Nairobi male clinic. But two important elements to be considered are confidentiality, and integration with other male reproductive health services.

- Males generally prefer clinics that offer a range of reproductive-health services for men. In several examples, we have seen that integration or availability of other services on site, such as infertility, STD management,

and sexual-disorder management, had a positive impact on male FP services, and gave further credibility to programs, which in turn increased the number of acceptors.

- Programs targeting young males, particularly those dealing with contraception, are very rare. The Planned Parenthood Association of Ghana's model should be encouraged and disseminated in other countries.

Recommendations for Next Steps

- Close the knowledge-practice gap: As in so many population programs that seek to change behavior, male-involvement programs display a classic KAP-gap; that is, there is a gap between knowledge and practice, between what people know they should do and what they actually do. Motivational campaigns, IEC activities, print media, operations research, workplace programs, Daddies Clubs, sporting events—all these approaches have been used to increase men's share in parental responsibility. Condom social marketing has been used, leading often to increased in condom use mostly for STDs/AIDS prevention. Male clinics succeeded in increasing vasectomy acceptors by offering good counseling and comprehensive reproductive health services. All of them have led to high level of awareness of family planning; however acceptance rates have remained relatively low. Therefore addressing this gap should be the next step in future programs.

- Include evaluation in program design: There is a need for better program design including evaluation. Most of the programs presented in this paper did not have an appropriate evaluation component. Those which did evaluate the effectiveness of their programs, such as the second Zimbabwe male motivation project, should be encouraged to use the results to adjust programs to achieve these desired goals.

- Exchange experiences: Program officers and managers working in the field should be brought together in order to exchange their experiences with current approaches, evaluate their relative successes and failure, highlight the success stories, and identify new strategies and directions for current and future programs. During that gathering, answers should be found to two key questions: a) How do we move from high level of awareness to high level of support and acceptance? b) How can we improve communication between couples about reproductive-health issues?

- Target messages to men: Special messages, targeted to men, should encourage them to be responsible and caring, and to discuss FP with their

partners. There is a need to target men as a primary audience with family-planning messages that emphasize the economic benefit of having fewer children, and create a new role model for men that portrays responsible men as those who discuss family size and contraception with their partners. In future campaigns, care should be taken to emphasize the need for the husband and the wife to share decisions.

- Pay attention to education and services for young men: It is important to introduce family-planning knowledge into the secondary schools and university as preparation for young people for future responsible parenthood. The most successful programs seem to be those which see sexuality education as a life-long process, beginning with programs to help parents teach their children, male and female alike, throughout their developmental years. Research has concluded that programs working with parents and children, first in separate groupings and later together, are by far the most successful in ensuring ongoing dialogue and the most meaningful behavioral change (IPPF, 1984).

- Provide advocacy training: There is a need for strong advocacy training for program managers, service providers, teachers, and male opinion leaders, in order to enable them to advocate and propagate family planning in their respective communities.

- Move urban lessons to rural areas: Most of the male-involvement initiatives are in big cities(urban areas). However, the inhabitants of the big cities are only a small proportion of the African population in most countries, most of whom live in the villages and rural areas. Moreover, the dependency of women on men is stronger in rural areas than in big cities. Therefore, there is a need to look at ways to expand or replicate these initiatives in the rural areas in order to reach this majority and have a greater impact.

- Learn about the male audience: There is a need for additional research. The first lesson of audience research is to "know your audience." Information on male attitudes, needs, and preferences is essential, also, understanding the needs and attitudes of men relating to sexuality is essential for the development of programs. Qualitative research should be carried out to look for answers to these questions: 1) What are the factors for further acceptance of family-planning programs by men? 2) What is men's role in fertility decision making? 3) How does a couple reach consensus on the choice and use of a contraceptive methods? 4) What are the determining factors for the acceptance or refusal by a woman to involve her partner in her reproductive health decision? 5) What are ser-

vice providers' thinking and attitudes towards men's and adolescent boys' involvement in reproductive health?

In addition, research on male methods should be pushed forward. There are only two major modern male contraceptive methods. This is often used by men as a good argument for not being involved in family planning, and can reinforce the image of a family program too often thought of as exclusively female. The practice of contraception cannot and should not the sole responsibility of women. The responsibility for contraception should be shared equally between men and women. In order to make this a reality, more vigorous attempts should be made to develop a more acceptable male contraceptive (IPPF, 1984).

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Table of Contents

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